

Closing Gaps Between Cannabis Policy and Scientific Understanding



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More than three quarters of Americans now live in a county with a cannabis dispensary (<https://tinyurl.com/57t4bz8w>), and, for the second year in a row, nationally representative self-reported data on substance use show daily or near-daily cannabis use surpassed daily or near-daily alcohol use in the United States in 2023 (<https://tinyurl.com/25m95nzm>). Cannabis advertising across the United States is diverse and widespread, and the cannabis market was estimated to be a more than \$40-billion industry by the end of this year (<https://tinyurl.com/dnvxdtmn>). In 2022, the Biden administration issued a presidential proclamation to pardon offenses for cannabis possession, and, in 2024 (<https://tinyurl.com/5frmfzvw>), they announced plans to reclassify cannabis from a Schedule I drug on the Controlled Substance Act to Schedule III



(<https://tinyurl.com/44d8uz8u>), indicating some medical benefits of cannabis. As the cannabis landscape continues to evolve, our understanding of the health effects of cannabis use and how to protect the public's health must also continue to improve.

Gaps in the scientific knowledge base on the therapeutic effects of cannabis use and harmful health outcomes have been identified as being especially important given that states and territories across the country are increasingly legalizing cannabis for medical and non-medical adult use (<https://tinyurl.com/44asnbpdp>). To address some of these gaps, in 2020, the Centers for Disease Control and Prevention established the Cannabis Strategy Unit (CSU). CSU's role is to coordinate cannabis activities across the agency and outline a strategy to monitor and address the use of and exposure to cannabis and its associated health and social effects (<https://tinyurl.com/2bf5p9u6>).

Monitoring cannabis use trends and advancing research are two of the CSU's strategic pillars. Given the continually evolving nature of policies legalizing medical and nonmedical adult cannabis use, leveraging multiple surveillance systems to better understand the epidemiology of cannabis use and research and evaluation studies is warranted. Such studies can improve our understanding of outcomes associated with cannabis use, particularly among

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HISTORY CORNER

26 YEARS AGO

Initiation of Use of Alcohol, Cigarettes, Marijuana, Cocaine, and Other Substances in US Birth Cohorts since 1919

Individuals born before and after World War II differed dramatically in the range and extent of their drug use. . . . In the 1930–1940 cohort, only 3 drugs were used by more than 1% before age 35: alcohol (84%), cigarettes (78%), and marijuana (6%). In the 1951–1955 cohort, 10 drugs were used by more than 5% before age 35. . . . The largest increases were for marijuana (50% in the 1951–1955 cohort vs 6% in the 1930–1940 cohort) and cocaine (19% vs 0.9%). . . . Both marijuana and cocaine use attained peak levels (55% and 17%, respectively) in the 1961–1965 cohort, but the most rapid increase occurred in the late 1960s for marijuana use, as the 1946–1950 cohort entered adulthood, and in the 1970s for cocaine use, as the 1951–1955 cohort entered adulthood. . . . The different trends in use of major drug types suggest the need to qualify an important insight of epidemiological theory—that addictive substances are epidemiologically linked in individual life cycles like a series of sequential stages or “gateways.”

From *AJPH*, January 1998, pp. 27–32

populations at increased risk for negative outcomes (e.g., youths, pregnant and postpartum persons, workers, and culturally, racially, and ethnically diverse populations who have been negatively impacted by differential policing of cannabis use) and those who use cannabis for medical reasons. As cannabis consumption among working adults increases with changing legalization, so too does the need for research to address the impacts of cannabis use on worker injuries and illness and workplace safety and health programs and practices (<https://tinyurl.com/44asnbpd>). Research and evaluation efforts can also improve our understanding of the impact of policies legalizing cannabis use on the prevalence of cannabis use, cannabis use

disorder, and related health and social effects.

By compiling research articles and editorials from some of the leading cannabis researchers, academics, leaders, and organizations, it is our hope that this supplement contributes to our understanding of cannabis use and narrows the gap between cannabis science and policy. We hope the information provided in this supplement will be helpful to public health practitioners, state-level policymakers, health care providers, and cannabis regulators as they navigate this challenging landscape. *AJPH*

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HISTORY CORNER

52 YEARS AGO

Decriminalization, Demythologizing, Desymbolizing, and Deemphasizing Marijuana

[The National Commission on Marijuana and Drug Abuse] concludes that there is little proven danger of physical or psychological harm from experimental or intermittent use of marijuana, including the resinous mixtures commonly used in this country. The risk lies in heavy, long-term use of the most potent preparations. The experimenter and intermittent user develops little or no dependence on the drug and no demonstrable organ damage. The heavy user shows strong psychological dependence. Organ damage, particularly pulmonary function, is possible in this group. Specific behavior changes are also found . . . The Commission studied the relationship of marijuana and crime. It came to the conclusion that marijuana does not cause violent or aggressive behavior. In fact, it was said to dampen down such tendencies in users . . . But the Commission's fine work is in trouble . . . [Harry] Anslinger, for example, predicted that adoption of its recommendations would result in 'a million lunatics filling up the mental hospitals and a couple of hundred thousand more deaths on our highways.' The unkindest cut of all, however, came from U. S. Surgeon General, Jesse L. Steinfeld who disagreed openly with its key recommendations and asserted that President Nixon felt the same way.

From *AJPH*, August 1972, pp. 1151–1152